# ATTACHMENT 2
# CMS 1500 claim form instructions for hearing services

(For claims submitted after HIPAA implementation)

Use the following claim form completion instructions, **not** the claim form's printed descriptions, to avoid denial or inaccurate Medicaid claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* for more information about the EVS.

### Element 1 — Program Block/Claim Sort Indicator

Enter the claim sort indicator in the Medicaid check box for the service billed.

| Claim Sort Indicator | Provider Type/Service |
|---|---|
| T | Audiologist (audiologist services) or speech and hearing clinic. |
| D | Audiologist (servicing and supplying of hearing aids) or hearing instrument specialist. |

### Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or the EVS to obtain the correct identification number.

### Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

### Element 3 — Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

### Element 4 — Insured's Name (not required)

### Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence, if known.

### Element 6 — Patient Relationship to Insured (not required)

### Element 7 — Insured's Address (not required)

### Element 8 — Patient Status (not required)

### Element 9 — Other Insured's Name

Commercial health insurance must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid.

If the EVS indicates that the recipient has dental ("DEN") or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), Vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, **and** the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes **must** be indicated in the **first** box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

| Code | Description |
|---|---|
| **OI-P** | PAID by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured. |
| **OI-D** | DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer. |
| **OI-Y** | YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to:<br>✓ The recipient denied coverage or will not cooperate.<br>✓ The provider knows the service in question is not covered by the carrier.<br>✓ The recipient's commercial health insurance failed to respond to initial and follow-up claims.<br>✓ Benefits are not assignable or cannot get assignment.<br>✓ Benefits are exhausted. |

*Note:* The provider may not use OI-D or OI-Y if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill Wisconsin Medicaid for services that are included in the capitation payment.

### Element 10 — Is Patient's Condition Related to (not required)

### Element 11 — Insured's Policy, Group, or FECA Number

Use the **first** box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Submit claims to Medicare before submitting claims to Wisconsin Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does not have any Medicare coverage, including Medicare Cost ("MCC") or Medicare + Choice ("MPC"), for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate:

| Code | Description |
|---|---|
| **M-5** | **Provider is not Medicare certified.** This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for dates of service (DOS) before or after their Medicare certification effective dates. Use M-5 in the following instances:<br>*For Medicare Part A (all three criteria must be met):*<br>✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided.<br>✓ The recipient is eligible for Medicare Part A.<br>✓ The procedure provided is covered by Medicare Part A.<br>*For Medicare Part B (all three criteria must be met):*<br>✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B, but the provider was not certified for the date the service was provided.<br>✓ The recipient is eligible for Medicare Part B.<br>✓ The procedure provided is covered by Medicare Part B. |
| **M-7** | **Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances:<br>*For Medicare Part A (all three criteria must be met):*<br>✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.<br>✓ The recipient is eligible for Medicare Part A.<br>✓ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.<br>*For Medicare Part B (all three criteria must be met):*<br>✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.<br>✓ The recipient is eligible for Medicare Part B.<br>✓ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. |
| **M-8** | **Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances:<br>*For Medicare Part A (all three criteria must be met):*<br>✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.<br>✓ The recipient is eligible for Medicare Part A.<br>✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis).<br>*For Medicare Part B (all three criteria must be met):*<br>✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.<br>✓ The recipient is eligible for Medicare Part B.<br>✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis). |

### Elements 12 and 13 — Authorized Person's Signature (not required)

### Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

### Element 15 — If Patient Has Had Same or Similar Illness (not required)

### Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

### Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source

Speech and hearing clinics are required to complete this element. Audiologists and hearing instrument specialists should refer to the list of hearing instrument codes in the Hearing Services Handbook to determine whether they are required to complete this element. If required, enter the referring physician's name and six-character Universal Provider Identification Number (UPIN). If the UPIN is not available, enter the eight-digit Medicaid provider number or the license number of the referring physician.

### Element 18 — Hospitalization Dates Related to Current Services (not required)

### Element 19 — Reserved for Local Use

If a provider bills an unlisted (or not otherwise specified) procedure code, a description of the procedure must be indicated in this element. If Element 19 does not provide enough space for the procedure description, or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s). In this instance, indicate "See Attachment" in Element 19.

### Element 20 — Outside Lab? (not required)

### Element 21 — Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

### Element 22 — Medicaid Resubmission (not required)

### Element 23 — Prior Authorization Number

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF) or Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS1). Services authorized under multiple PA requests must be billed on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

### Element 24A — Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for a range of dates for the rental of a hearing instrument, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field, and the last day of rental in the "To" field in MM/DD/YY or MM/DD/YYYY format.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in the MM/DD/YY or MM/DD/YYYY format in the "From" field, and the subsequent DOS in the "TO" field by listing only the date(s) of the month. For example, for DOS on December 1, 8, 15, and 22, 2003, enter 12/01/03 or 12/01/2003 in the "From" field and enter 08/15/22 in the "To" field.

*Note:* It is allowable to enter a range of dates for the rental of a hearing instrument on one line if only indicating the actual days that the item was rented or only indicating dates from a single month.

It is allowable to enter up to four DOS per line if:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same place of service (POS) code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge **per detail line** in Element 24F.)
- The number of services performed on each DOS is identical.

- All procedures have the same HealthCheck or family planning indicator, if applicable.
- All procedures have the same emergency indicator, if applicable.

### Element 24B — Place of Service

Enter the appropriate two-digit POS code for each service. Refer to Attachment 1 of this *Wisconsin Medicaid & BadgerCare Update* for a list of applicable POS codes.

### Element 24C — Type of Service (not required)

### Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code. Refer to the Hearing Services Handbook for Wisconsin Medicaid-allowable codes for hearing services.

#### Modifiers

Enter the appropriate (up to four per procedure code) modifier(s) in the "Modifier" column of Element 24D. Please note that Wisconsin Medicaid has not adopted all national modifiers.

### Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in Element 21.

### Element 24F — $ Charges

Enter the total charge for each line item. Providers are required to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Medicaid benefits.

### Element 24G — Days or Units

Enter the appropriate number of units for each line item. Always use a decimal (e.g., 2.0 units).

### Element 24H — EPSDT/Family Plan (not required)

### Element 24I — EMG (not required)

### Element 24J — COB (not required)

### Element 24K — Reserved for Local Use

Enter the eight-digit Medicaid provider number of the performing provider ***for each procedure***, if that number is different than the billing provider number in Element 33. Any other information entered in this element may cause claim denial.

### Element 25 — Federal Tax I.D. Number (not required)

### Element 26 — Patient's Account No. (not required)

Optional — Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

### Element 27 — Accept Assignment (not required)

### Element 28 — Total Charge

Enter the total charges for this claim.

### Element 29 — Amount Paid

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9.) If the commercial health insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.